

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



IMAAVY IV ORDERS

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/> NKDA Allergies:			

PHYSICIAN INFORMATION

Physician Name:	Practice Name:
NPI:	Office Contact Name: Office Contact #:
Phone: Fax:	Email (for updates):

REFERRAL STATUS

New Referral Referral Renewal Medication/Order Change Benefits Verification Only Discontinuation Order

Name of Medication: **IMAAVY**
INDICATIONS AND USAGE IMAAVY is indicated for the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive

ICD-10*: _____

PRE-MEDICATION

Tylenol PO 650mg 1000mg other _____
 Solumedrol 125mg IV other _____
 Benadryl 25mg 50mg other _____ IV PO

Medication _____ Dose _____ Route _____
 _____ (other) _____ (other)

WARNINGS AND PRECAUTIONS
<https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/IMAAVY-pi.pdf>

IMAAVY ORDERS

Initial dosage of IMAAVY is 30 mg/kg administered once then
 Maintenance dosage of IMAAVY 15 mg/kg every 2 weeks
 x 1 year after initial dose (unless otherwise specified)
 X _____ doses

PT WEIGHT
_____ kg
_____ lbs

**NOTES/ADDITIONAL COMMENTS:
LAB DRAW REQUEST:**

Labs: _____
 Freq: _____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Recent Labs
_____ Recent Progress and Vaccination Status
_____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____
Provider _____ Phone _____ Fax _____

Diagnosis Code: _____
Order/dosage: _____
Signature: _____